Total Retiree Advantage Illinois
Your Trail to Better Health

State of Illinois
TRAIL Medicare Advantage Enrollment Form
For Plan Year 2015 (January 1 through December 31, 2015)

IF THE ABOVE PREPRINTED MAILING ADDRESS IS INCORRECT, ENTER THE CORRECT ADDRESS ON THESE LINES.

Complete **SECTION 1** if you are **ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME, WISH TO CHANGE** your current Medicare Advantage health plan or dental election or are **ELECTING TO OPT OUT** of the State's coverage.

SECTION 1: MEMBER INFORMATION

Please fill in the information below as it is on your Medicare card.

MEDICARE HEALTH INSURANCE

Last Name

First Name MI

Medicare Claim Number

Is Entitled to

HOSPITAL (PART A) Effective Date

MEDICAL (PART B) Effective Date

Date of Birth Gender ☐ M ☐ F

Social Security Number

Email

Home Phone Cell Phone

County of Residence

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

SECTION 2: RESIDENTIAL ADDRESS

RESIDENTIAL ADDRESS (if different from **mailing** address)
You must enter a physical location in the section below if the address preprinted above is a P.O. Box
(Do not enter a P.O. Box or a General Delivery Address)

Do you reside in a nursing home or assisted living facility? ☐ **Yes** ☐ **No**
If YES, the nursing home/assisted living facility address must be entered in the address section below:

Street Address Apt. or Suite

City State Zip Code County

Complete **SECTION 3** if you are **ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME, WISH TO CHANGE** your current Medicare Advantage health plan or dental election or are **ELECTING TO OPT OUT** of the State's coverage.

SECTION 3: 2015 COVERAGE ELECTIONS

OUR SYSTEM SHOWS YOUR CURRENT COVERAGE IS:

DEPENDENT COVERAGE – If you have a spouse, civil union partner or disabled child currently enrolled on your State of Illinois coverage, they will remain enrolled and will have the same coverage that you have. If you change your health plan or add a dependent to your coverage, your dependent must also sign page 3. To add or drop a dependent, complete page 4.

HEALTH PLAN ELECTION

Preferred Provider Organization (PPO) – available nationwide

☐ UnitedHealthcare PPO (AE)

Health Maintenance Organization (HMO)
(availability varies by Illinois county – see map on page 14 of the TRAIL Decision Guide)

Check the box for your HMO plan election:

☐ Coventry Advantra HMO (AB)

☐ Health Alliance MAPD HMO (AF)

☐ Humana Health Plan HMO (AD)

☐ Humana Benefit Plan HMO (AC)
(Livingston and Knox Counties Only)

Enter the Primary Care Physician's (PCP) name and either the NPI or PCP number below:
(NPI and PCP numbers can be found on the plan's website or by calling the plan)

Member's PCP Name	Spouse/Partner's PCP Name	Other Dependent PCP Name
Member's NPI or PCP#	Spouse/Partner's NPI or PCP#	Other Dependent NPI or PCP#

OPT OUT OF HEALTH, PRESCRIPTION AND VISION COVERAGE

☐ **I wish to opt out of the State's Medicare Advantage TRAIL Program.** I understand that by opting out I will no longer have health, prescription or vision coverage through the State of Illinois effective January 1, 2015. I also understand that I cannot opt back into the health, prescription and vision coverage until a future TRAIL Open Enrollment Period.

DENTAL ELECTION – Complete only if **you wish to change your DENTAL election.**

☐ I am currently enrolled in the dental plan but would like to drop the coverage effective January 1, 2015.

☐ I am **NOT** currently enrolled in the dental plan and would like to elect the coverage effective January 1, 2015.

LIFE INSURANCE ELECTION

Life insurance options for annuitants and survivors vary and are limited. If you would like to change your life insurance coverage, contact your retirement system (on the front of this form). Medical underwriting will be required to add or increase Member Optional Life. A Statement of Health (underwriting) application is available by calling Minnesota Life at (888) 202-5525 or on the TRAIL website at **www.cms.illinois.gov/thetrail**.

SECTION 4: SIGNATURE OF ENROLLEES

By signing below, I am agreeing that I have read and understand the important information on page iii of the Instruction Sheet.

SIGNATURE OF APPLICANT or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

SIGNATURE OF SPOUSE/CIVIL UNION PARTNER or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

SIGNATURE OF OTHER DEPENDENT or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), the signature certifies that: (1) this person is authorized under State law to complete this enrollment and (2) documentation of this authority is available upon request by the Plan or Medicare.

AUTHORIZED LEGAL REPRESENTATIVE

If you are the authorized legal representative, you **must** sign the 'Signature of Applicant' above and provide the following information:

Last Name _____ First Name _____

Street Address _____ Apt. or Suite _____

City _____ State _____ Zip Code _____

Phone Number _____ Relationship to Applicant _____

☐ I would like the enrollee's State of Illinois TRAIL healthcare insurance information mailed to my address.

If you are the legal representative signing for this member you must provide a copy of the legal document giving this authority, such as a Power of Attorney or a court order indicating that you are the member's legal guardian, along with this application. If the documentation is not submitted by the application due date, the application will be denied. Members whose application is denied due to lack of documentation from the legal representative will not have health, prescription drug or vision coverage through the State of Illinois and will not be allowed to re-enroll in the program until a future TRAIL Open Enrollment Period.

Complete **Section 5** if you wish to **add or drop a Medicare dependent** (spouse/partner or child). If you wish to add a Non-Medicare dependent, see page iv of the Instruction Sheet.

SECTION 5: DEPENDENT COVERAGE

1. Drop a Dependent – if you wish to **drop** a currently enrolled dependent from your coverage, check the box for the relationship of the dependent you are dropping. If the dependent is a child, indicate the first name of the child. Coverage will be terminated effective January 1, 2015.

☐ Spouse or Civil Union Partner

☐ Child, indicate name: _____

2. Add a Dependent – if you wish to **add** a dependent to your Medicare Advantage plan coverage, complete the information below. **You may only use this form to add a dependent that has Medicare Parts A and B.** Please fill in the information below as it is on your dependent's Medicare card. Documentation, as indicated on page iv of the Instruction Sheet, is required to add a dependent. To add more than two dependents, download a copy of this enrollment form from the TRAIL website.

Dependent 1: Relationship of Dependent to Member ☐ **Spouse** ☐ **Child** ☐ **Civil Union Partner**

MEDICARE HEALTH INSURANCE

_____
Last Name

_____ _____
First Name MI

_____
Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____
Effective Date

MEDICAL (PART B) _____
Effective Date

_____ Gender ☐ M ☐ F
Date of Birth

_____
Dependent's Social Security Number

Does this dependent have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

Dependent 2: Relationship of Dependent to Member ☐ **Spouse** ☐ **Child** ☐ **Civil Union Partner**

MEDICARE HEALTH INSURANCE

_____
Last Name

_____ _____
First Name MI

_____
Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____
Effective Date

MEDICAL (PART B) _____
Effective Date

_____ Gender ☐ M ☐ F
Date of Birth

_____
Dependent's Social Security Number

Does this dependent have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

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